



## FINAL GRANT REPORT

*Building a Statewide System of Consumer-Responsive, Integrated Care  
for People with Chronic Illness or Disability*

Robert Wood Johnson Grant # 23246

October 1, 1994 – December 31, 1999

(no-cost extension 10/1/97 – 12/31/99)

Current Date: March 9, 2000

### **1. What were the project's objectives and to what extent has the project met these objectives?**

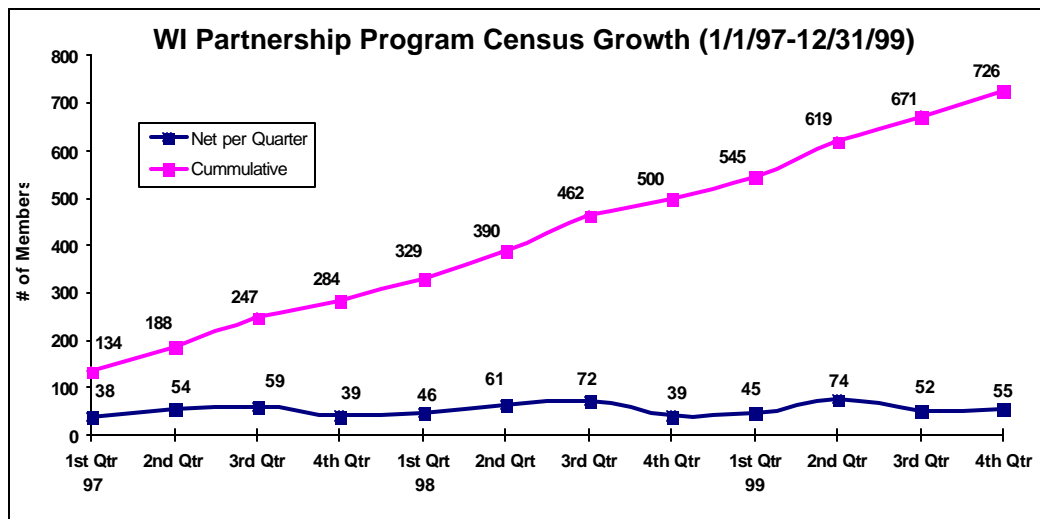
In our October 1994 grant application, we proposed to develop, implement and research two innovative managed care models that would integrate acute and long term care through community-based organizations. One model would serve frail elderly people and the other would serve adults with physical disabilities. We planned to call this innovative model the "Wisconsin Partnership Program." We proposed that a key feature of the Partnership Program would be a multidisciplinary team that consisted of the member, a social worker, a registered nurse, and a nurse practitioner. This team would be responsible for coordinating the member's care. The Partnership Program would emphasize the role of the nurse practitioner in bridging the gap between medical and social services so that fragmented services would be integrated.

By the end of the grant period, we projected that the elderly model would be fully operational; the physical disabilities model would be pilot-tested; the quality assurance system would be designed and implemented; and research results would be available to assess operational progress, consumer experiences, quality of care, and impact of key design features. Finally, we stated that a program development process would be designed and tested with secondary sites for the two models to ensure that the Robert Wood Johnson Foundation grant became a self-sustaining system of replication and model improvement.

That was five years ago. Today, looking back at our original grant proposal it is obvious that we have accomplished our original objectives. During the past five years we have:

- Implemented the Partnership Program at four community-based organizations serving residents in five counties in Wisconsin;
- Secured an 1115/222 Medicaid/Medicare waiver from the federal Health Care Financing Administration in October 1998 which allows the Partnership organizations to receive capitation payments from both Medicare and Medicaid;
- Served nearly 1,000 people in the Partnership Program over the course of the grant; net enrollment on December 31, 1999 was 726 members (see the following page for a chart of census growth over the last three years);

- Developed the infrastructure and capacity necessary to operate a model that integrates health and long term care services for people with chronic conditions and illnesses.
- Reduced service fragmentation through specific implementation strategies, including unified financing, continuity across the spectrum of provider types and service settings, the interdisciplinary care team, and comprehensive service plans emphasizing consumer choice, communication, prevention, continuity and quality.



The Wisconsin Partnership Program is a huge success and demonstrates that integrating acute and long term care is feasible, can be implemented by community-based organizations, and works for multiple age and target groups in various geographic settings, urban and rural. Members also represent the full range of American cultural diversity, including émigrés from Russia, Cambodia, China, Mexico, South America, and the Indian subcontinent. A summary of detailed accomplishments, organized by Partnership site, is included in the next section.

The objectives of the Wisconsin Partnership Program can be organized into the following three areas:

1. **WPP Sites** - Establish and implement the organizational and program structure for the Partnership Program for elderly people and people with physical disabilities;
2. **DHFS** - Establish the program infrastructure within the Department of Health and Family Services to support and monitor the Partnership Program; and
3. **Quality** - Conduct interviews and observations of management, clinical team members, participants and participants' families to identify service quality standards. Demonstrate those quality standards in program implementation and oversight.

**Objective 1 – The Objectives of the WPP sites during the grant were to:**

- Provide comprehensive care to people who meet nursing home admission criteria;
- Improve functional and clinical outcomes of consumers;
- Retain the continuity of care and preventive health elements successfully incorporated in current PACE sites;
- Allow consumers to retain choice of primary care physicians and to participate in the program without attending adult day care;
- Maximize the ability of consumers to live in their own homes, to participate in community life, and to be engaged in the decision-making processes regarding their own care;
- Minimize reliance on institutional care (hospitals, nursing homes, and group living environments over 4 beds); and
- Reduce acute/long term care costs primarily by lowering the need for acute care intervention (e.g., hospitalization), compared to the fee-for-service system.

**Objective 1 –Accomplishments:****Community Living Alliance<sup>1</sup> (CLA)**

CLA is small community-based non-profit organization in Madison that serves adults with significant physical disabilities that reside in Dane County. CLA's background is as an Independent Living Center, and as such, fosters the independence of members by developing and operating in a way that seeks their participation in the governance of the organization, staffing, program design, quality improvement, program evaluation and resource allocation. CLA was selected as a Partnership site in October 1994 as a result of a Request for Proposals issued by the Department of Health and Family Services.

*Census* – CLA began enrolling members in May 1996. At the end of the grant there were 140 members enrolled; a net growth of approximately 2.5 members per month. Enrollment at CLA has not been as rapid as might have been hoped.

CLA's slow census growth can partly be attributed to the prominence of members with significant mental health issues and/or multiple diagnoses and degenerative disabilities. Approximately 42% of CLA's members have a diagnosed mental health and/or substance abuse problem. Further, only 46% of members have what many might regard as "typical" physical disabilities, i.e., spinal cord injuries, MS, cerebral palsy, etc. The added complexity presented by the comorbidity of mental health and alcohol and drug issues along with significant physical conditions has prompted CLA to approach new referrals slowly, making sure that all necessary services are in place prior to enrollment.

The majority of CLA members have chronic health conditions such as diabetes and heart and lung diseases. Many of these members have multiple diagnoses and complex conditions and in many cases are unwilling to follow a plan of care without significant involvement of the care management team. This has meant that the team size to member ratio has remained small, with 25 members per team.

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<sup>1</sup> Formerly Access to Independence. In 1998, Access to Independence separated into two corporations – Access to Independence and Community Living Alliance (CLA). The Wisconsin Partnership Program for people with physical disabilities began operating under CLA on January 1, 1998.

- When CLA first started serving people in the Partnership Program, CLA anticipated the majority of their members would have personal care and other long term care needs. However, the participants that are actually enrolled have significantly more complex medical and social issues than was anticipated. This complex population required CLA to develop the infrastructure needed to operate a program with more expertise in acute and primary health care than originally expected. In order to function effectively in the medical arena, policies, procedures and adequate oversight of activities are necessary to assure good quality of care. This is a challenge for small community-based social service organizations.
- *Staff Recruitment and Selection* – Each interdisciplinary team at CLA consists of .5 FTE nurse practitioner, one registered nurse, and one social service coordinator. In addition to the team, “float” nurses and team coordinators facilitate assessments and follow-up on health concerns. At the end of the grant, CLA had seven interdisciplinary teams in place to serve their members plus a total of 146 personal living assistants.
- *Provider Network* – Currently, CLA works with 19 clinics, 3 hospitals and 2 health systems in Dane County. CLA’s provider network also includes durable medical equipment (DME) providers, chiropractors, pharmacies, AODA providers, and nursing homes.
- *Physician Recruitment* – The CLA Partnership Program currently has 34 physicians on its panel for members to choose from. Physician recruitment has been slow but steady throughout the project. CLA has experienced difficulty finding physicians to agree to take more than a few (up to 5) of their members. Medicaid recipients are often viewed in the physician community as being very difficult to work with, unmotivated to follow the plan of care and often missing appointments. CLA has attempted to overcome this barrier by stressing the support the Partnership team (especially the nurse practitioner) provides to the physician. One role of the nurse practitioner is to form a collaborative practice arrangement with the physician, which relieves the physician of some of the more routine care provided to members and, also, augments the primary care that the physician provides.
- *Outcomes* – During the past three years, CLA has seen improved clinical and functional outcomes for their members. In the broadest sense, CLA members prefer to live in their own homes. At the end of 1999, 94% of CLA members were living outside of an institutional or substitute care setting. Historically, 98% of members have lived in their own home or that of a relative.

Other utilization data shows an increase in nursing home days between 1998 and 1999 which reflects the medical complexity of members, and to some extent, the lack of availability of personal care workers. Emergency room visits were also higher in 1999. According to a recent study conducted internally at CLA, most emergency room visits were during the day and most were authorized by staff. Hospital admissions are also growing. Nurse Practitioners evaluate every admission to determine whether or not it could have been prevented, and in 99% of cases found the admission was not preventable. This reflects the acuity of the members that CLA is serving. CLA members require a high number of medications with medications for depression being the highest category, followed by analgesics/narcotics.

**Elder Care of Dane County (Elder Care)**

In December 1995, Elder Care of Dane County became the first agency to begin enrolling members into the Partnership Program. Elder Care has been a community-based provider of long term care services in Madison since 1976. Elder Care entered the arena of integrated service delivery via the PACE program in January 1995. This experience provided Elder Care the opportunity to develop the organizational capacity necessary to administer a complex, comprehensive, capitated program such as the Partnership Program. Elder Care served as an excellent resource for the other Partnership organizations as they brought up their individual programs.

- *Census* – Elder Care began enrolling members in December 1995, and they have served 335 members over the five-year grant period. On December 31, 1999 there were 241 members enrolled. On average, Elder Care enrolls 8 members per month. Elder Care's largest referral source has been the Dane County waitlist for long term care services and other county referral sources.
- *Staff Recruitment and Selection* – Each interdisciplinary team at Elder Care consists of nurse practitioner, two registered nurses, and one social service coordinator. At the end of the reporting period, Elder Care had six interdisciplinary teams.
- *Provider Network* – Elder Care's provider network for acute and primary care is comprised of four area hospitals and five participating physician group practices with 32 clinics.
- *Physician Recruitment* – Elder Care's physician panel is comprised of 71 physicians. Of these, 73% are trained in internal medicine and 27% are trained in Family Practice; 7% of all physicians have advanced certification in geriatrics.

Overall, Elder Care has found that a limited or restricted panel of physicians has been more successful than contracting with every physician that members bring to the program. At first Elder Care sought to enroll all willing physicians in their panel, however, this arrangement proved unmanageable and hindered the development of collaborative working relationships between physicians and nurse practitioners, which are essential to the success of Partnership. A limited network of physicians is more manageable in terms of assuring quality, ensuring that providers understand the Partnership model, and administering Medicaid and Medicare requirements for subcontracted services.

- *Outcomes* – The majority of Elder Care's members live in the community with 86% living in a private home, 2% living in a nursing facility and 13% living in a CBRF or Adult Family Home.

In order to determine whether emergency room visits and hospital admissions were necessary, Elder Care staff developed and implemented a process for retrospective review of admissions and emergency room visits, using a standard data collection form. Staff evaluate the appropriateness of care preceding and concurrent with these events, and maintain records of their findings. Most events were found to be not preventable. Records are tracked by the quality committee to monitor for trends and identify opportunities for specific quality improvement activities

**Community Care for the Elderly (CCE)**

In 1990, Community Care for the Elderly, located in Milwaukee, was the first agency in Wisconsin to provide an integrated model of community-based, managed long term care for older adults through its PACE program. CCE was the second site selected to demonstrate the Partnership model for the frail elderly and began serving members in 1996. CCE is demonstrating a variation of the Partnership Program model where interdisciplinary teams are physically located in centralized locations where member enrollment is the heaviest. Two of CCE's interdisciplinary teams are physically located at elderly-only housing units and one team is co-located in a hospital where CCE has developed a dementia adult daycare program. Partnership services are also taken out to members not living in these congregate housing situations but who are in the immediate geographical area. CCE finds that this type of arrangement works well in a large urban area, and CCE considers their development of interdisciplinary teams located closer to the member's residence or neighborhood to be one of the major accomplishments of their program.

- *Census* – CCE began enrolling members in 1996; on December 31, 1999, 162 members were enrolled. CCE has served a total of 233 people over the course of the last three years. There is a greater net growth enrollment in CCE's Partnership Program than in its PACE program.
- *Staff Recruitment and Selection* – CCE works with four interdisciplinary teams and as mentioned above, each team serves a specific geographic area. The size and make-up of each team varies depending on the area served.
- *Provider Network* – CCE works with seven area clinics and all three major hospital networks in the Milwaukee area.
- *Physician Recruitment* – On December 31, 1999 there were a total of 28 primary care physicians involved in the Partnership Program. CCE has over 200 specialists available to serve participants.

Prior to its involvement in Partnership, CCE operated a PACE site which uses a staff physician. The use of community physicians to provide primary care is a significant departure from the PACE model. After approximately three years of experience with the Partnership model, CCE reports that the use of community-based physicians as providers of primary care appears to function adequately. CCE believes the model necessitates the utilization of an experienced nurse practitioner to accomplish the frequent monitoring and intervention of multiple chronic diseases in the population.

- *Outcomes* – CCE reports that the service delivery model utilizing increased in-home services and a reduced interdisciplinary model of care has been effective in providing care to members. However, the CCE Partnership Program continues to rely upon the infrastructure developed for PACE, and it is difficult to evaluate the effect of the organization separately.

Partnership members at CCE have enjoyed a greater than 90% community living situation over the history of the program. As of December 31, 1999, 151 members lived in the community, two members lived in a nursing home, and nine members lived in a CBRF.

Within the past year, CCE has noted trends in higher utilization of pharmacy and inpatient hospitalizations for Partnership members. CCE plans to monitor these trends closely in the future.

### **Community Health Partnership<sup>2</sup> (CHP)**

CHP was the first “replication” site for the Partnership demonstration. The Department of Health and Family Services selected CHP in 1995 through a competitive request for proposals (RFP) process. CHP is the only Partnership agency to **serve both target groups** (frail elderly 65 and over and adults with disabilities ages 18-64) in a **three county area** (Eau Claire, Dunn and Chippewa Counties). When CHP began their Partnership Program, the other three Partnership sites were already operational and a lot of the foundation had already been laid by the other sites. CHP benefited from the other sites, who pitched in to offer technical assistance and invaluable advice.

- *Census* – After 19 months of planning, CHP started to enroll members on May 1, 1997. At the end of the grant period, enrollment was 183 (133 elderly, 50 physically disabled); an average of 5.9 enrollments per month.
- *Staff Recruitment and Selection* – CHP works with five interdisciplinary teams. Each team is comprised of a nurse practitioner, registered nurse, social services coordinator, and team assistant. In addition, CHP has with 120 daily living assistants available to serve members.
- *Provider Network* – Since CHP is located in a rural area and covers a geographic territory of three counties, developing a provider network has been challenging. Partnership sites are required to have all services available to Partnership members within a reasonable travel distance. This requirement has forced CHP’s network to be extensive in size; some providers are even located in neighboring counties, as these providers are the most accessible to some of their members. CHP has 148 health and long term care providers in their network. However, the choice of providers is actually much larger due to several contracts covering more than one agency.

CHP has found that dentists are the most resistant to contracting with them. CHP reimburses dentists the same as what the State Medicaid program is paying them, and this, in many instances, is well below their cost of providing dental services. Nevertheless, CHP is currently contracting with 15 dentists in the three county area—enough to meet the needs of their members. CHP also notes that many home health agencies view CHP as “competition” and have actively verbalized their concerns. Many agencies believed CHP would take their clients away from them and not use the services of a home health agency because the care management team incorporates both RNs and NPs who are able to provide direct care. Over the course of the grant, CHP has been able to develop a more collaborative relationship with home health agencies and the relationship between CHP and home health agencies is dramatically better.

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<sup>2</sup> On January 1, 1999, the Partnership Program separated from the Center for Independent Living in Western Wisconsin to form a new private non-profit organization called Community Health Partnership, Inc.

- *Physician Recruitment* – CHP works with 75 primary care physicians in three major groups. Of these physicians, 68% are in family practice and 32% are in internal medicine. At least three of the family practice doctors are certified in Geriatrics.
- *Outcomes* – The majority of CHP members live in the community with 89% living in a private home, 8% living in a nursing facility, and 3% residing in a CBRF or group home. Other utilization outcomes show that, on average, the member to medication ratio is 9.25 medications per member.

In 1998, CHP conducted a study of all members to compare hospital and nursing home days 6 months prior to enrollment and 6 months after enrollment. CHP found that hospitalizations and nursing home days substantially decreased after enrolling in the Partnership Program. Hospitalizations decreased from 88 to 49 and nursing home placements decreased from 31 to 8.

**Objective 2 – The objectives of the Department of Health and Family Services during the grant were to:**

- Develop and implement a self-sustaining system of program and organizational development, model improvement and replication;
- Create a design whose essential elements can be applied to multiple age and target groups in various geographic settings, urban and rural; and
- Secure a dual 1115/222 waiver that integrates Medicaid and Medicare.

**Objective 2 – Accomplishments:**

The Wisconsin Partnership Program was developed through the assistance of the Robert Wood Johnson Foundation and has become a self-sustaining system. State staff originally funded by RWJ are now fully funded by Wisconsin. The individual Partnership organizations are operating independently of State sponsorship and are fully operational under the 1115/222 waiver.

Full implementation under the dual waiver has been the major accomplishment over the last year. HCFA conducted a site visit in November of 1998 so that the organizations could become operational as soon as January 1, 1999. Since that time, negotiations have continued on such items as the Medicare+Choice contracts between HCFA and the sites, the reporting of budget neutrality data to HCFA, and the creation of a grievance and appeal process that incorporates both Medicare and Medicaid principles and is transparent to consumers. DHFS and HCFA have worked collaboratively on quality oversight, and DHFS is facilitating HCFA's contracted evaluation, producing enrollment and utilization data and coordinating evaluation activities with the Partnership contractors.

**Objective 3 – The objectives for researching and assuring and improving quality during the grant were to:**

- Carefully research and document implementation experiences and consumer responses; and
- Develop and test quality assurance protocols and quality indicators based on the expressed values of consumers.



**Objective 3 – Accomplishments:**

Over the past five years, the quality research team, led by Dr. Barbara Bowers at the University of Wisconsin-Madison School of Nursing has conducted formative and summative research in order to understand how to think about quality from a variety of perspectives (provider, consumer, managerial), and how to design systems that promote quality in integrated, interdisciplinary, consumer centered care models.

To achieve these objectives, the quality research team took part in creating, and then studying, the interdisciplinary care management model centered on a team of providers that works in collaboration with the members being served in the program. Because such a model of care had never been implemented, the focus of the research team was on whether this integrated model could not only improve the quality of long term care, but lead to more consumer centered care.

Over the course of this demonstration project, the research team learned that an integrated care management model, despite all of the implementation challenges it creates, does indeed result in more consumer centered, long term care. In fact, from the consumer's point of view, high quality care necessarily assumes consumer-centered care. The research also suggests that differences in how people define quality – between consumers and providers, among providers, and between the program and oversight agencies – influences the ability of Partnership organizations to provide the highest quality care.

Several research-based products were developed to assist with the replication and implementation of integrated care programs like Partnership. Much of the research team's work focused on the development of the interdisciplinary care team, and the shift in roles of team members that result from working collaboratively. Quality improvement/focused study guidelines were also developed as ongoing quality systems at each Partnership site. An evaluation designed to provide an opportunity for Partnership members to provide feedback about quality of care/service delivery was also developed. Each of the quality research products reflect the perspectives of consumers, family members and health and long term care providers. A list of the research products developed during the grant is included in the attached bibliography.

DHFS has incorporated the research findings in the Partnership Operations and Oversight Protocols. Quality oversight in Partnership adapts components of the Quality Improvement System for Managed Care (QISMC) to the specific quality standards of long term care recipients as identified in the research.

**2. *What internal shortfalls, limitations, or challenges did the project encounter that were related to its funding level, design, collaborations, staffing, operations, or other project factors? Did any challenges internal to the National Program affect the project?***

From the start, the Partnership organizations and the State recognized the need to purchase or develop an IT system for Partnership. A system was needed that would not only facilitate case management and serve as a medical record, but would also capture encounter data and be able create utilization reports. Given the complexity of the Partnership model, the IT system requirements were also complex and such a system was not readily available for purchase. In 1996, the Partnership organizations began collaborating on the development of an IT system in order to meet the specific needs of Partnership.

This IT system has evolved over time and is currently being tested at three of the Partnership organizations. The delay in the release of the final IT system has impaired the efforts of the Partnership organizations to maintain many records in an electronic format. This has affected good utilization review methods and the ability of the sites to deliver timely and accurate encounter data. The release of the final IT system is now scheduled for November 2000.

Another challenge that has faced the Partnership organizations is obtaining appropriate levels of care (LOC) determinations for Partnership members. Inconsistencies caused by both inter-rater reliability and the difference related to institutional versus community care have both fiscal and public relations impact on Partnership. Currently, a tool is being developed and tested for Family Care, the State's long term care redesign program, that will hopefully deliver more consistent level of care determinations across settings and raters. When this new tool is validated in Wisconsin, Partnership will seek an amendment to its 1115/222 waiver to allow the new tool to substitute for the current method of establishing level of care.

Partnership was designed to serve either people who are frail (age 55 and older) or adults with physical disabilities. The frequency of comorbidity of these conditions with mental health and alcohol and other drug abuse (AODA) issues was unexpected. The frequency, as high as 65% at some sites, has challenged the abilities of the Partnership organizations to respond to the needs of the whole person. Organizations have started to respond by acquiring the expertise necessary to integrate this challenging area of service into their benefit package. In addition, the State is leading an effort to develop protocols to provide guidance to the organizations in addressing the compliance issues associated with serving people who have mental illness and AODA issues.

Partnership seeks to build, to the greatest extent possible, a physician panel from primary care physicians brought to the program by consumers wishing to enroll and/or by the Partnership sites efforts to recruit primary and specialty physicians. However, one of the lessons learned in Partnership is that there can not be unrestricted growth of the physician panel. Quality of care, utilization management and integrity of the model are dependent on the establishment of a strong collaborative working relationship between the primary care physicians and the nurse practitioners (NP). The relationships become increasingly difficult when the NP's time and abilities are stretched between too many physicians. Site's have worked hard to strike the proper balance between the size of enrollment and the physician panel. They have tested several strategies including securing physicians' commitments to serve a minimum number of Partnership members, recruiting whole clinics at one time-gaining efficiencies in time management and physician orientation, and removing physicians from the panel who do not demonstrate "buy-in" to the Partnership model. Experimentation continues to find the optimal ratio.

As census has grown, the Partnership organizations have also attempted to fine-tune the interdisciplinary team, both in terms of the number of members a team can effectively serve, and in the proportion of professionals within the team. Cost effectiveness hinges on each team carrying a "full" caseload. However, the work associated with each participant varies with complexity and acuity, in both health and social domains. Participant needs vary from person to person and from time to time. In response, the Partnership organizations have adjusted the team's relative full time equivalents (FTE) of each profession (Nurse Practitioner, Registered Nurse, Social Worker, and sometimes a clerical worker) in different combinations without reaching any

solid conclusions about the “right” mix or ratio to participants. It has become increasingly clear that a tool to assesses participant complexity and acuity to predict workload would be helpful.

**3. *What challenges or successes were caused by factors external to the project?***

The largest external challenge that Partnership has faced (and will continue to face) is the ability of the Partnership sites to recruit and retain quality staff in the current marketplace. The unemployment rate in Wisconsin is extremely low. The Partnership organizations have had to implement creative solutions to overcome this barrier. This challenge has affected all levels of staffing, from nurses to daily living assistants.

Another challenge that continues to face Partnership is the changing federal landscape that forms the backdrop for implementation of the 1115/222 waiver. The Partnership waiver was written to respond to U.S.C 1395. During the negotiation of the waivers, Medicare+Choice (M+C) became a reality and the regulations were published shortly before Partnership implementation. HCFA chose to contract with Partnership organizations as M+C entities. As a result, the Partnership program, at all levels, has found it necessary to adapt to the new and changing requirements of M+C as federal policy is defined and regulations are interpreted. Constant vigilance is required to evaluate Medicare+Choice requirements against the application, the terms and conditions of the waiver and the Partnership protocols adopted in the waiver.

In its approach, the Partnership program seeks to recognize the existing physician relationships that people, newly referred to the program, bring along with them. This has led, in some cases, to the development of large physician panels serving relatively few enrollees. It is a constant challenge to organizations to orient physicians to the Partnership approach, manage the relationships with physicians, and communicate effectively with physicians in trying to provide optimal health and social outcomes to members. As a result, organizations have implemented a number of strategies to limit growth of the physician panels and enhance the quality of NP/physician relationships. Most of the organizations now request that new physicians added to the panels serve a minimum number of enrollees. Also, organizations have used their medical directors extensively to assist with communication and orientation in an effort to emphasize the team approach to case management and fully integrated care.

The budget neutrality requirements under the 1115/222 waiver have also been a challenge for the Partnership Program. The initial establishment of budget neutrality was a matter of much negotiation prior to securing the dual waiver. Further, finalizing budget neutrality reporting requirements was not resolved with HCFA until a year after the waiver became operational. Wisconsin is confident that the Partnership Program will prove itself to be budget neutral. In 1999, the first year that the dual waiver became operational, the budget neutrality cap was \$3,005; the average capitation paid to the Partnership sites was only \$2,513 – a difference of \$492.

**4. *If you are working in collaboration with other organizations, or depend on other organizations or institutions to meet the objectives of this project, how did those collaborations work?***

The Wisconsin Partnership Program is the result of an ongoing collaboration of many entities. It would not be possible without the collaborative efforts of the Robert Wood Johnson Foundation,

federal Health Care Financing Administration, Wisconsin Department of Health and Family Services, University of Wisconsin-Madison, and the four Partnership organizations. In addition, collaboration with various advocacy groups such as the Wisconsin Coalition of Advocacy and the Independent Living Centers have played a major role in making Partnership the consumer responsive program that it is.

The Health Care Financing Administration has shown a real willingness to collaborate in the development of this innovative program. The agency has demonstrated flexibility and the assigned project officers have been very helpful to Wisconsin in navigating the federal bureaucracy. HCFA was and continues to be of assistance, helping the Partnership organizations to become fully operational. Federal budget constraints limited staffing at HCFA, so project officers were at times overworked and less than fully available.

While the Center for Delivery Systems Development at the Wisconsin Department of Health and Family Service has had the lead in the planning, development and implementation of the Partnership Program, other segments of State government have also been significant collaborators. The Division of Health Care Financing has taken the lead in the areas of contracting, quality, and capitation rate development. Units of the Division of Supportive Living have also been participants in Partnership. Departmental restructuring and related change initiatives have both delayed our work and benefited from it. Finally, the support of the five counties hosting the Partnership organizations - Dane, Dunn, Chippewa, Eau Claire and Milwaukee - has been critical to the development and implementation of the program.

Within the Department of Health and Family Services, Partnership has led the move away from regulation of structure and process and moved toward outcomes contracting. This requires us to rethink the way government approaches quality, in terms of measures, monitoring, staffing and organizational responsibilities.

**5. *With a perspective on the entire project, what have been its key dissemination activities?***

With the help of the Robert Wood Johnson Foundation, the State has developed two videos about the Partnership Program. These videos have been extremely well received and will continue to function as a key means of dissemination.

The Partnership Program also has a web site ([www.dhfs.state.wi.us/aboutdhfs/osf/wpp/osf-wpp-index.htm](http://www.dhfs.state.wi.us/aboutdhfs/osf/wpp/osf-wpp-index.htm)). This site contains general overview information as well as all of the research products developed by the research team at the University of Wisconsin. The web site also contains monthly census data dating back to December 1998 and updated census data is published monthly.

Staff from the various Partnership organizations, as well as staff from the State, have presented at conferences across the nation. The most notable dissemination activity however, is the day-to-day phone discussions with different states and provider types seeking to implement a Partnership-like delivery model for consumers of long term care.

## 6. What were the project's other sources of support?

Federal, State, and county funds, and in-kind support enabled the Partnership Program to build a substantive state and site infrastructure and extend the original RWJF grant from 3 years to 5 years in duration.

Federal Medicaid administrative match was requested and approved for state project positions and direct costs, consultant contracts, and University of Wisconsin research contracts. At the end of the grant, the continuation of the project was ensured when state funds replaced the RWJF funds for the state project positions, and these positions were converted to full-time permanent state positions.

County funds played a key role in helping to finance start up costs. Each site had a collaborating county that offset expenses up to \$500,000 per year for the first three years for staffing and direct costs.

In addition, administrators and policy analysts in the Office of Strategic Finance and Division of Health Care Financing provided significant in kind support, particularly during the first two years of the grant.

## 7. What was the significance of what was accomplished by the project?

In the original grant application, we emphasized reducing fragmentation in the care system:

*“The Partnership Program is designed to eliminate fragmentation in long term care programs and of the health care system in general. Some harmful consequences of fragmentation include:*

- Unnecessary Spending: Fragmentation in finance yields cost mismanagement. Each separate program and agency seeks to contain expenditures in its own area of responsibility, without regard to total cost. Rational acts, such as cost-shifting, contribute to an irrational and undesirable total result.*
- Lower Quality of Care: Fragmentation in service delivery means that people depend on multiple providers who treat them not as a whole person, but as an unconnected amalgam of broken parts, illnesses, and conditions.*
- False Assurance of Quality: Fragmentation in finance and service delivery results in a compartmentalized quality assurance system. Each individual service is held to chosen standards, but the interrelationships between services are ignored. We are assured that each “part” is working fine even though the “whole” may be dysfunctional.*
- Resistance to Improvement: Fragmentation in management means that managers are responsible only for “parts” and no one is responsible for the “whole”. Management is then blinded (and often resistant) to needed improvements.”*

To reduce service fragmentation, the Wisconsin Partnership Program has been developed as a fully integrated managed long term care program. A unified funding stream eliminates conflicting incentives – providers are selected and coordinated by a single payer agency. A unified interdisciplinary team works with the service recipient through all care situations and settings until death or disenrollment. Care is holistic; cohesive goals are integrated into a single

plan. Quality is considered from the perspective of the member, and across the spectrum of providers and care settings.

In many respects, Partnership resembles PACE - the only other fully integrated managed care program in the country. However, what are of the greatest significance in Partnership are the dissimilarities from PACE. PACE primary care physicians are employed by the PACE site. While this gives PACE sites greater control in utilization management than Partnership, the small physician panel can be a disincentive for people who already have a well established relationship with a primary care physician. Ideally, Partnership allows members to maintain the relationship they have already established with their doctor. Partnership's services are primarily home based and do not rely on a day center as a structure in which to provide services. Unlike PACE, Partnership serves individuals with significant physical disabilities in addition to the frail elderly. Partnership draws on Wisconsin's rich history of consumer-centered, community based long term care to shift the focus from the care provider to the consumer.

The differences from PACE, highlighted above, as well as the more traditional approaches found in home and community based waivers and Wisconsin's Community Options Program, qualify as truly significant variations from a pre-existing service structure in Wisconsin and the country.

Partnership has begun to collect data with the intent of establishing performance benchmarks for community based long term care. Very little is known about what constitutes good performance in health or long term care for frail populations. While PACE tracks some information, it is framed in the context of the PACE model. Wisconsin's other Home and Community Based Waiver Programs manage long term care, but are not responsible for participant health services. Managed health care organizations do track health variables, but blend statistics for well and ill populations. As managed care organizations begin to recognize the value of health screening and targeted managed care, they may look to Partnership for benchmarks for these special populations.

**8. What lessons did you, as a project director of a project in a National Program, learn from undertaking this project?**

1. **From vision to reality: *Things change*.** The application to the Foundation for funding the Partnership demonstration was visionary in its scope and ambitious in its expectations. The reality is that it took a long time to operationalize the vision; some things worked and some things didn't; and some things – very few – never were accomplished.
2. **Prime project manager characteristics required: *Patience and persistence*.** Almost everything took longer than expected, and there were surprises around every corner. Once we obtained the grant, it took a very long time to get staff positions approved so we could start; and just when we thought the waiver was about to be approved, HCFA reorganized: Persistence.

The sites struggled to enroll members, but they neglected to monitor level of care, so lost money; the nurses and social workers started to work as an interdisciplinary team but quality audits revealed that they didn't always record what they discussed: Patience.

3. **Community-based organizations *can* learn health care** ...with the following suggestions to make things easier:
    - Put people on the board of directors who have strategic expertise: marketing, fiscal, human resources and clinical experts help grow the organization from folksy to professional.
    - Become administrative sooner: put a strong management team in place *before* you can afford it. These managers will establish the systems and prepare the plans so that you *can* afford it.
    - Be good collaborators. Integrated health and long term care is a collaboration between purchaser and provider – the state and the community-based organization – and the relationship should be interdependent and dynamic should foster good organizational learning and quality improvement on both fronts.
  4. **It takes years to build the desired data and quality systems** that are needed to support integrated health and long term care programs. Start early, and keep at it. Patience and persistence.
  5. **Take risks and be flexible.** Vision and planning are good, but at some point, take a risk and “just do it.” It is in the *doing* that the *learning* occurs. And while you are learning, when things are a mess and difficult to sort out and everyone is overworked and testy, be *flexible* because there’s more than one solution to a problem.
  6. While you are learning, **build the systems needed** to anticipate problems, and to identify and solve problems quickly when they occur.
  7. **Don’t ever, ever forget why you are doing this work:** to improve the quality of life of very vulnerable people who want to have the health care and social supports they need to live where they want to, to go where they want to, be with the people they want to be with, and go when they want to go.
9. **What are the post-grant plans for the project if it does not conclude with the grant?**

### Continued Funding

The operations of the Wisconsin Partnership Program did not end with the RWJ grant. Continued funding for state staff previously provided by grant monies was appropriated in the most recent state biennial budget. Four full time positions and one part time position at the Department continue to be dedicated to the Partnership Program. This assures that the development of infrastructure, research aimed at the refinement of operations, and technical assistance to the Partnership organizations will continue.

### Expansion and Replication

Expansion of the Partnership demonstration continues to be a goal of the Department. Negotiations are underway with the Health Care Financing Administration (HCFA) to allow for an expansion to serve additional target populations. Two of the existing Partnership organizations have already been approached by geographically adjoining counties to provide services and offer greater choice to consumers.

**Grants**

Wisconsin is applying for a grant from the Robert Wood Johnson Foundation – Medicare/Medicaid Integration Program to further research objectives and build clinical expertise within the Partnership Program. Experience in demonstrating that clinical pathways addressing the multiple and complex needs of members, particularly people with physical disabilities, are lacking or non-existent.

Partnership organizations have experienced a high degree of co-morbidity in their memberships, adding mental illnesses and alcohol and other drug abuse to the complexity of the social and medical conditions they must address. This added complexity is not recognized in level of care considerations and is not reflected in the current method of rate setting. Wisconsin will use additional RWJ funding to do the research to support and help refine level of care and rate setting methodologies to better reflect the complexity of the people served.

Developing appropriate indicators of quality specific to the Partnership Program remains a challenge. Efforts are underway to isolate and define measurable, critical indicators of quality in the Partnership model. Accepted standards of quality that apply to medical or social aspects of care do not adequately capture the improvements in consumer outcomes that are facilitated by integrating medical and social services. Measuring advances in quality facilitated by the interplay of an integrated service model is evident but not fully understood. We will be seeking an appropriate set of indicators to measure these advances in quality.

**Dissemination**

Wisconsin has been and will continue to be a willing provider of information regarding the Partnership Program. We will continue to publish research and develop technical assistance documents available to any that request them. Partnership Program has a web site and future plans include the expansion of this site to provide access to all Partnership materials as well as video produced with financial support from the Robert Wood Johnson Foundation during this grant.

**10. How do you assess the Foundation's role and the NPO's role?**

In May 1999 a Partnership conference took place in Wisconsin Dells and was attended by staff from the various Partnership organizations, State staff, as well as representatives from other states planning new approaches to serving people with chronic conditions. Marc LaForce and Jay Wussow from the Center for Health Care Strategies (CHCS) actively participated in this conference. Their ability to bring a more global perspective to the work underway in Wisconsin via the Partnership Program served to emphasize to staff the groundbreaking nature of their efforts. This encouragement in “Navigating Uncharted Waters” was very helpful.

On a different occasion, Marc and Jay met with management staff from the various Partnership organizations and with state staff. This meeting helped Partnership to identify and solidify some of the learning that has taken place over the life of the grant. This learning is currently being articulated in a monograph to aid in its dissemination to other interested parties. This monograph is a joint effort of the Wisconsin Partnership Program and the CHCS.

Over the life of the grant, the funding and other support provided by the Robert Wood Johnson Foundation has been critical to the development of the infrastructure, the research and training,



marketing, and the dissemination activities of the Wisconsin Partnership Program. In 1997, the Foundation granted a no-cost extension of the original grant. During the extension, Wisconsin was able to complete its negotiations with HCFA and obtained approval of Wisconsin's 1115/222 waiver request. The waiver was implemented in 1999 and all four Partnership organizations are now operating fully integrated, Medicare/Medicaid managed care programs. The State of Wisconsin and the Partnership organizations are grateful to the Robert Wood Johnson Foundation for helping make the Partnership Program a viable reality for the members served in the program.

The reporting activities required by the Foundation provided the impetus to periodically assess the progress being made in the program as a whole and at each of the various organizations. It is easy to get caught up in wrestling with individual issues and miss the progress being made over time. The quarterly and annual reports were often the catalyst for us to take the time to gain some perspective.

*We are grateful to the Robert Wood Johnson Foundation for their support and cooperation in the development and implementation of the Wisconsin Partnership Program.*

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*Module I: Team Members Professional Identification & Cross-Discipline Awareness*

Designed to assist team members in understanding discipline-specific attitudes, priorities, logic and expertise and to reflect on the professional expertise on the interdisciplinary team, the similarities and differences among the professionals, and how professional identification can affect practice.

*Module II: Providing Consumer-Centered Care (in development)*

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programs in integrated care settings. Prepared for the Department of Health and Family Services and the Robert Wood Johnson Foundation, 1998.

- Esmond, S. & Bowers, B. *Enrolling New Members in a Consumer Centered, Integrated Program*. Case study of one interdisciplinary team's approach to intake and enrollment of new program members. Identifies the complexities to designing integrated, consumer centered intake/enrollment systems. Prepared for the Department of Health and Family Services and the Robert Wood Johnson Foundation, 2000.
- Esmond, S. & Bowers, B. *Consumer Centered Careplanning in Integrated Care Programs*. Narrative report on the challenges to creating consumer-centered careplans, as well as specific initiatives designed by Partnership program staff to address these challenges. Prepared for the Department of Health and Family Services and the Robert Wood Johnson Foundation, 2000.

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"State Receives Waivers to Combine Medicaid, Medicare Funding," *BNA's Health Care Policy*. Vol. 6 (November 16): no. 45, 1998.

### **Brochures**

"Wisconsin Partnership Program." Department of Health and Family Services, Office of Strategic Finance. May 1999. Also available in Hmong and Spanish.

### **Newsletters**

*WPP Project Notes*. Madison, Wisconsin, Department of Health and Family Services, Office of Strategic Finance. Two issues; Fall 1996 and Spring 1997. Approximately 300 copies mailed per issue.

### **Sponsored Conference, Meetings, and Workshops**

"Capture the Learning-First Annual Partnership Retreat," April 1-2, 1997, Madison, Wisconsin. Attended by over 200 people from Partnership sites, the State, county, University of Wisconsin School of Nursing, and other stakeholders.

"Navigating Uncharted Waters," May 25-26, 1999, Wisconsin Dells, Wisconsin. Attended by over 200 participants, which included staff from the various Partnership organizations, the State and county, and the federal Health Care Financing Administration, as well as representatives from other states interested in the Partnership Program model. Four presentations given:

- "Navigating Uncharted Waters," F. Marc LaForce, M.D.
- "A Fleet Exercise," William Clark.
- "Consumers at the Helm," Kevin Mahoney, Ph.D.
- "The Crew is the Glue: Interdisciplinary Teamwork in Emerging Health Care Systems," Theresa Drinka, Ph.D.
- The conference also hosted 17 excursion sessions for program participants.

**Presentations**

- Mary Rowin and Barbara Bowers, “Quality Assurance Retreat,” October 28-29, 1996, College Park, Maryland. University of Maryland Center on Aging and the Robert Wood Johnson Foundation.
- Barbara Bowers, “Aging Network in Transition Forum,” November 5, 1996, Madison, Wisconsin.
- Fran Genter, Judy Hodgson, and Mary Rowin, “Wisconsin County Human Services Association (WCHSA) Fall Conference,” December 4-6, 1996.
- Thomas Hamilton, “Alliance for Health Care Reform,” March 10, 1997, Washington, D.C. Briefed congressional aides and media on Wisconsin Partnership Program and issues serving dually eligible populations.
- Mary Rowin, John Bott, Gail Gaustad, and Karen Musser, “Developing the Components of a Consumer-Focused System of Care,” at the 1997 Annual RWJ Grantee Meeting, April 30 - May 1, 1997, San Francisco, California.
- Barbara Bowers, “Excellence in Community-Based Case Management,” June 4, 1997, St. Paul, Minnesota.
- Mary Rowin, presentation to the Advisory Committee to the Wisconsin Department of Health and Family Services Medicaid program, June 4, 1997, Madison, Wisconsin.
- Mary Rowin, to the Partners’ Planning Managed Care Conference for People with Physical Disabilities, July 16, 1997, Minneapolis, Minnesota.
- Barbara Bowers and Thomas Hamilton, “Consumer Views of Quality,” at the Annual State Health Policy Conference, August 10, 1997, Portland, Maine.
- Sharon Ryan and Karen Hodgson, presentation to the American Associates for Mental Retardation, September 11, 1997. Presenters: Sharon Ryan and Karen Hodgson.
- Thomas Hamilton, presentation at the Long Term Care Workshop, Agency for Health Care Policy and Research, Washington D.C., October 1997.
- Mary Rowin, “WPP/County Collaborations,” at the Wisconsin Statewide Long Term Support Conference, October 1997.
- Mary Rowin, presentation to the 20th Century Coalition of United Cerebral Palsy Organizations, October 3, 1997, Milwaukee, Wisconsin.
- Thomas Hamilton, presentation at the Annual State Health Policy Conference, August 10-12, 1997. Portland, Maine.

- Mary Rowin, “Managed Care and Persons with Disabilities and Chronic Illness,” AHCPR User’s Liaison Program, Chandler, Arizona, November 1997.
- Thomas Hamilton, presentation and discussion of dual Medicare/Medicaid waiver request made to Nancy Ann Min Deparle, HCFA Administrator, March 1998.
- Barbara Bowers, Mary Rowin, and Lisa Kregel, “Consumer-Centered Care in Integrated Programs,” Maryland Center on Aging and Robert Wood Johnson Foundation, Baltimore, May 1998.
- The following presentations were made at the Long Term Care Redesign Care Management Demonstration Workshop for counties on May 18 and 20, 1998:
  - “Case Management,” Sara Roberts and Linda Burns.
  - “Cost and Service Utilization,” Tom Schaefer and Sherrel Walker.
  - “Consumer Involvement,” Lynn Breedlove, Karen Hodgson, and Owen McCusker.
  - “Building a Provider Network,” John Bott and David Sievert, presenters.
  - “Organizational Change,” Chuck McLaughlin, Jeanne Prochnow, and Meg Gleeson.
- Barbara Bowers, “Recognizing Consumer Priorities in Organizational Design and Service Delivery,” New England Consortium, Edmund Muskie School of Public Service, New Hampshire, July 1998.
- Mary Rowin, presentation to a Health Systems Seminar regarding Medicare/Medicaid Integration, University of Wisconsin-Madison, July 26, 1998.
- Barbara Bowers, “Designing Integrated, Consumer-Centered Care Systems,” Grant County, August 1998.
- The following presentations were made at the Family Care Workshop for Care Management Organization Demonstration Sites in Wausau, Wisconsin on August 25-26, 1998:
  - “Quality Management in Community-Based Organizations,” Julie Horner, Barbara Bowers, David Sievert and Lynn Polacek, presenters.
  - “Assessment, Care Planning and Resource Allocation,” Lynn Polacek and Alice Mirk.
  - “Managing Cost and Quality,” Tom Schaefer, Larry Paplham, and Jack Reiners.
- Barbara Bowers, Owen McCusker, and Karen Hodgson, “Integrated Care Models for People with Physical Disabilities,” September 1998, Houston, Texas.
- Steve Landkamer, presentation to the county COP coordinator meeting, Appleton, Wisconsin, September 1998.
- Mary Rowin, presentation at the Building Health Systems Program Annual Grantee Meeting, September 17-18, 1998, Baltimore, Maryland.
- Meg Gleeson and Chris Hess, “Lapham Park Residential Complex Venture Project,” at the National Council on Aging Annual Conference, November 1998, Washington, D.C.

- Mary Gavinski, M.D. and Jeanne Prochnow, “The Changing Face of Long Term Care of the Elderly,” November 11, 1998, Milwaukee, WI. Sponsored by Aurora Health Care, Older Adult Services.
- Steve Landkamer, presentation at the Medicare/Medicaid Integration Program Technical Assistance Workshop, March 4-5, 1999, College Park, Maryland.
- Karen Musser and Lora Wiggins, “Function and Composition of the Interdisciplinary Team,” March 25, 1999, Massachusetts. Invited presentation to the Massachusetts Medicaid Senior Care Organization Technical Assistance Workshops.
- Jeanne Prochnow, “Wisconsin Elder Care: Legal and Financial Issues, 1999”, April 15, 1999, Milwaukee, WI.
- Kirby Shoaf, “Alternative Models of Integrated Programs,” May 1999, Washington, D.C. National PACE Association Annual Public Policy Forum.
- Lora Wiggins and David Sievert, “Tips for Starting and Managing a Senior Care Organization,” October 4, 1999, Massachusetts. Invited conference presentation to the Massachusetts Medicaid Senior Care Organization Technical Assistance Workshops.
- Barbara Bowers with Paul Saucier, “Designing Guidelines for Consumer Centered Care Systems,” Association for Health Care Policy Research (AHCPR) User Liaison Conference, December 1-2, 1999.
- Jeanne Prochnow and Steve Landkamer, “Designing Health Care Systems that Work for People with Chronic Illnesses and Disabilities,” December 2, 1999, Houston, TX. Sponsored by the National Academy for State Health Policy.

### **Press Release**

“State’s Health Care Partnership Program Approved,” press release issued by Wisconsin Governor Tommy G. Thompson, regarding HCFA’s approval of Wisconsin’s 1115/222 waiver. October 26, 1998.

### **WWW, Electronic Media, and Audio-Visuals**

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- *Wisconsin Partnership Program – Participants and Their Stories*. WI Department of Health and Family Services, 2000. 50 copies produced; 10 distributed. Available free of charge.